JUN.11.2001 4:23PM NO.949 P.2

# Early and Periodic Screening Diagnosis and Treatment TRACKING FORM 2-4 DAY

TO BE FILLE	D IN BY OFFI	CE STAFF:				
Last Name		First Name	AHCCCS ID		D.O.B.	Age
}			•	•		
Primary Care Pro	vider	<del></del>	Date of Examinati	On	Health Plan Name	
		•	J. D. LINGUILLIAGO		Manual India	
Birth Wt.	Weight	Percentile	Height	Percentile	Head Circumference	Percentile
	İ	2		,		
TO DE MILES	VAT WAY THE CALL					<del></del>
INITIAL HISTO	IN BY PROVID	<u>ek</u>	•		•	
Was history for			[ ] Yes	f 3	No	
Is a 2nd newbo	orn screening (Pk	U, etc.) necessary?	Yes		No	
Was Hepatitis P	given in the ho ASSESSMENT		[ ] Yes		No	
MOTRITIONAL	Supplements:	[ ] Breast Feeding [ ] Fluoride	[ ] Formula	(type) Vitamins	[ ] Iron	
SENSORY ASSI	ESSMENT Visi	ion: Within normal limi	its? [j	Yes [ ] N	No, Refer	
DEVELOPMEN	eni Ekippedda iati	aring: Within normal limi NT Age appropriate?			No, Refer	
	AND ADDEDOME	AT WE abbiobilists:	( )	Yes [] 1	<b>Vo</b>	
PHYSICAL EXA	AM .	COMMENTS	SSESSMENT & I	N A N		
Are the following		COMMENTS, A		LAN		
THE THE IOHOWII	rig norman: Yes	No				
Skin						
Head						
Eyes (red-reflex)	)			•		
Ears	·					•
Nose						
Mouth/Throat						
Nodes						
Heart						
Lungs				•		
Abdomen (cord	)					
Rectum					·	
Fem. Pulse			,			
Ext. Gen.						
Hip Abduc.			•			
Extremities						
Spine		Follow-up neede			[ ] Y	es [] No
Neuro		IMMUNIZATIO	N ASSESSMENT	,		,
Other			ceive all immuniz			es [] No
		is there a curren	t immunization re	cord in the medi	ical chatt? [ ] Y	es [] No
ANTICIPATOR	Y GUIDANCE			REF	ERRALS	
[ ] Postpartum	nting practices a adjustment s/sleep positionir vention	[ ] Individual	with the baby lity of infants ottle feeding lness		CRS WIC Specialty Other	
Next scheduled vi	sit	Clinician Name		Clin	ician Signature	
Was this claim cod	ded as an EPSDT V	Isit (HCFA-1500)?	[] Yes	[ ] No		

วันท.11.2001 4:23PM NO.949 P.3

#### Early and Periodic Screening Diagnosis and Treatment TRACKING FORM BY 1 MONTH

TO BE FILLED	IN BY OFFI	TE STAFF:				
Last.Name		First Name	AHCCCS ID		D.O.B.	Age
•				-		{ -
Primary Care Provide	der		Date of Examinat	ion	Health Plan Name	
				•		
Birth Wt.	Weight	Percentile	Height	Percentile	Head Circumference	Percentile
			·			
TO BE FILLED E	N BY PROVID	ER				<del></del>
HISTORY INIT						
	Was history for	rm completed?	[ ] Yes [	] No	,	
NUTRITIONAL A		B given in the hospital?  [ ] Breast Feeding	[ ] Yes [ [ ] Formula	) No		
	Supplements:	[ ] Fluoride	[-]	Vitamins	[ ] Iron	
SENSORY ASSES					Vo, Refer	
DEVELOPMENT	AL ASSESSME	ring: Within normal lim NT Age appropriate?			No, Refer No	
Respond	ls to sounds, re	sponds to parent's face an	d voice, follows w	rith eyes,		
(If suspic	cious, do specif	ic objective testing) Asses	sment Tool (name	•)		
PHYSICAL EXAM	VI	COMMENTS	SSESSMENT &	PLAN		
Are the following						
HE WE TOHOWING	-	No				
Skin						
Head						
yes (red reflex)						
Ears ( symmetrics	al)					
Nose	1 1					
Mouth/Throat						
Nodes						
Heart						
Lungs						
Abdomen						
Fem. Pulse			•			
Ext. Gen.				•		
Hip Abduc.				•		
Extremities						
Spine						
Neuro		Follow-up needs	ed?			es [] No
Other			N ASSESSMENT			<u> </u>
LAB/SCREENIN	C		ceive all immunia		2 113	les f 1 No
Hct./Hgb.		Is there a curren	t immunization r	ecord in the med	? ical chart? [ ] Y	les [] No les [] No
NTICIPATORY	GUIDANCE			REF	ERRALS	
] Injury preve		[ ] Infant De		1 1	CRS	
[ ] Sleep practic [ ] Sleep positio		[ ] Time to ca	all the doctor		WIC	
Bladder and	bowel habits	Plans for i		ļįj	Specialty	
) Nutrition	_		- •	[]	Other	
<del></del>						
Next scheduled visi	t	Clinician Name		Clin	ician Signature	



### Early and Periodic Screening Diagnosis and Treatment TRACKING FORM 2 MONTHS

Primary Care Provider    Date of Examination	TO BE FILLE	D IN BY OFFIC	CE STAFF:								
Birth Wt.   Weight   Percentile   Height   Percentile   Head Circumference   Percentile	Last Name			AHCCCS ID	<del> </del>	D.O.B.		Age			
Birth Wt.   Weight   Percentile   Height   Percentile   Head Circumference   Percentile			·		···						
TO BE FILLED IN BY PROVIDER  HISTORY INITIAL/INTERVAL  Comments  NUTRITIONAL ASSESSMENT [ ] Breast Feeding [ ] Formula (type)  SUNDJEMENTS [ ] Flooride [ ] Vitamins [ ] Iron  SENSORY ASSESSMENT Vision: Within normal limits? [ ] Yes [ ] No, Refer  Haring: Within normal limits? [ ] Yes [ ] No, Refer  DEVELOPMENTAL ASSESSMENT Age appropriate? [ ] Yes [ ] No  Vocalizes reciprocally, smalles responsately, attentive to voices, when prone-lifts head, neck, upper chest.  (If suspicious, do specific objective testing) Assessment Tool (name)  PPYSICAL EXAM  Are the following normal?  Yes No  Skim	Primary Care Pro	vider	·	Date of Examinati	ion	Health Plan Name					
T	Birth Wt.	Weight	Percentile	Height	Percentile	Head Circumference	e	Percentile			
T	TO BE FILLED	IN BY PROVID	ER		<u> </u>						
NOTETITIONAL ASSESSMENT   Stream   Breast Feeding   Formula (type)   Vitamins   Iron   SENSORY ASSESSMENT   Vision: Within normal limits?   Yes   No. Refer   No.			<del></del>								
Vocalizes reciprocally, smiles responsively, attentive to voices, when prone-lifts head, neck, upper chest.  (If suspicious, do specific objective testing) Assessment Tool (name)  PHYSICAL EXAM  Are the following normal?  Yes No  Skin	NUTRITIONAL ASSESSMENT [ ] Breast Feeding [ ] Formula (type)  Supplements: [ ] Fluoride [ ] Vitamins [ ] Iron  SENSORY ASSESSMENT Vision: Within normal limits? [ ] Yes [ ] No, Refer  Hearing: Within normal limits? [ ] Yes [ ] No, Refer										
Are the following normal?  Yes No Skin  Head  Ears (symmetrical)  Nose  Mouth/Throat  Nodes  Heart  Lungs  Abdomen  Fem. Pulse  Ext. Gen.  Hip Abduc.  Extremities  Spline  Neuro  Other  HAB/SCREENING  HAL/Higb.  HAL/Higb.  Tother child care providers  [] Yes [] No  NoN  ANTICIPATORY GUIDANCE  [] Family relationships  [] I CES  [] WIC  [] Talk to baby  [] J CES  [] WIC  [] Talk to baby  [] J Specialty  [] J Cinician Name  Clinician Signature	Vocali	zes reciprocally, s	miles responsively, attent	ive to voices, whe	n prone-lifts hea		st.				
Are the following normal?  Yes No  Skin  Head  Eyes (red reflex)  Ears (symmetrical)  Nose  Mouth/Throat  Nodes  Heatt  Lungs  Abdomen  Pem. Pulse  Eat. Gen.  Hip Abduc.  Eatremities  Spine  Neuro  Other  IAB/SCREENING  Het./Hgb.  HCL/Hgb.  Injury prevention  Noticipatory Guidance  [ ] Family relationships  [ ] Ves [ ] No  NANTICIPATORY Guidance  [ ] Injury prevention  [ ] Family relationships  [ ] CES  [ ] WIC  [ ] Talk to baby  [ ] Specialty  [ ] Pacifiers, bottle tooth decay  [ ] Other  Next scheduled visit  Clinician Name  Clinician Signature	PHYSICAL EX.	AM	COMMENTS, A	ASSESSMENT &	PLAN						
Sign	Are the followi				,						
Head  Eyes (red reflex)  Ears (symmetrical)  Nose  Mouth/Throat  Nodes  Heart  Lungs  Abdomen  Fen. Pulse  Ext. Gen.  Hip Abduc.  Extremities  Spine  Neuro  Other  IAB/SCREENING  Hct./Higb.  Follow-up needed?  IMMUNIZATION ASSESSMENT  Did this child receive all immunizations due today?  Is there a current immunization record in the medical chart?  I linjury prevention  I	Skin	Yes	No ,								
Ears (symmetrical) Nose Mouth/Throat Nodes Heart Lungs Abdomen Fem. Pulse Ext. Gen. Hip Abduc. Extremities Spine Neuro Other LAB/SCREENING Hct./Hgb.  Indian/Screening Hct./Hgb.  Indian/Screening Injury prevention Injury preventi	Head										
Ears (symmetrical) Nose Mouth/Throat Nodes Heart Lungs Abdomen Fem. Pulse Ext. Gen. Hip Abduc. Extremities Spine Neuro Other LAB/SCREENING Hct./Hgb.  Indian/Screening Hct./Hgb.  Indian/Screening Injury prevention Injury preventi	Eves (red reflex	t)									
Mouth/Throat   Mouth/			<del></del>    .		٠			,			
Mouth/Throat   Nodes   Heart	Nose	1 1									
Nodes Heart Lungs Abdomen Rem. Pulse Ext. Gen. Hip Abduc. Extremities Spine Neuro Other IAB/SCREENING Hct./Hgb. Follow-up needed?  IMMUNIZATION ASSESSMENT Did this child receive all immunizations due today? Is there a current immunization record in the medical chart? I highly prevention I linjury preve	Mouth/Throat										
Heart Lungs Abdomen Fem. Pulse Ext. Gen. Hip Abduc. Extremities Spine Neuro Other  LAB/SCREENING Hct./Hgb.  Did this child receive all immunizations due today? [] Yes [] No ANTICIPATORY GUIDANGE  [] Injury prevention [] Nutrition [] Nutrition [] Injury prevention [] Injury prevention [] Injury prevention [] Pacifiers, bottle tooth decay [] Specialty [] Talk to baby [] Other Next scheduled visit  Clinician Name  Clinician Signature	Nodes										
Abdomen   Fem. Pulse   Ext. Gen.	Heart										
Fem. Pulse  Ext. Gen.  Hip Abduc.  Extremities  Spine  Neuro  Other  LAB/SCREENING  Hct./Hgb.  Did this child receive all immunizations due today? [] Yes [] No Is there a current immunization record in the medical chart? [] Yes [] No  ANTICIPATORY GUIDANCE  REFERRALS  [] Injury prevention [] Family relationships [] Other child care providers [] WIC [] Sieep positioning/practices [] Talk to baby [] Specialty [] Pacifiers, bottle tooth decay  [] Other  Clinician Signature	Lungs										
Ext. Gen. Hip Abduc. Extremities Spine Neuro Other LAB/SCREENING Hct./Hgb.  Did this child receive all immunizations due today? Is there a current immunization record in the medical chart?  [ ] Yes [ ] No ANTICIPATORY GUIDANCE  REFERRALS  [ ] Injury prevention [ ] Nutrition [ ] Other child care providers [ ] WIC [ ] Specialty [ ] Fever education  [ ] Pacifiers, bottle tooth decay  [ ] Other  Next scheduled visit  Clinician Name  Clinician Signature	Abdomen										
Hip Abduc.  Extremitles  Spine  Neuro  Other  LAB/SCREENING  Hct./Hgb.  Did this child receive all immunizations due today?  Is there a current immunization record in the medical chart?  [] Yes [] No  ANTICIPATORY GUIDANCE  REFERRALS  [] Injury prevention [] Injury prevention [] Nutrition [] Other child care providers [] Talk to baby [] Specialty [] Specialty [] Pacifiers, bottle tooth decay  Clinician Signature	Fem. Pulse										
Extremities  Spine  Neuro Other  LAB/SCREENING Hct./Hgb.  Did this child receive all immunizations due today?  Is there a current immunization record in the medical chart?  [ ] Yes [ ] No  ANTICIPATORY GUIDANCE  [ ] Family relationships [ ] Other child care providers [ ] WIC [ ] Specialty [ ] Pacifiers, bottle tooth decay  Next scheduled visit    Clinician Name   Clinician Signature	Ext. Gen.										
Follow-up needed?     Yes   No	Hip Abduc.										
Neuro Other  LAB/SCREENING Hct./Hgb.  Did this child receive all immunizations due today? Is there a current immunization record in the medical chart?  [ ] Yes [ ] No  ANTICIPATORY GUIDANCE  [ ] Injury prevention [ ] Injury prevention [ ] Nutrition [ ] Other child care providers [ ] WIC [ ] Talk to baby [ ] Specialty [ ] Pacifiers, bottle tooth decay  Next scheduled visit    Clinician Name   Clinician Signature	Extremities										
Other  LAB/SCREENING Hct./Hgb.  Did this child receive all immunizations due today?  Is there a current immunization record in the medical chart?  [] Yes [] No  ANTICIPATORY GUIDANCE  [] Injury prevention [] Nutrition [] Other child care providers [] WIC [] Sleep positioning/practices [] Talk to baby [] Pacifiers, bottle tooth decay  [] Other  Next scheduled visit    Clinician Name   Clinician Signature	Spine										
IMMUNIZATION ASSESSMENT  Did this child receive all immunizations due today?  Is there a current immunization record in the medical chart?  [ ] Yes [ ] No  ANTICIPATORY GUIDANCE  [ ] Injury prevention [ ] Family relationships [ ] CRS [ ] Nutrition [ ] Other child care providers [ ] WIC [ ] Sleep positioning/practices [ ] Talk to baby [ ] Pacifiers, bottle tooth decay  [ ] Other  Next scheduled visit    Clinician Name   Clinician Signature	Neuro	1	Follow-up neede	ed?		. [	] Yes	[ ] No			
Did this child receive all immunizations due today?    Steep a current immunization record in the medical chart?   Yes   No	Other				Ţ	,					
ANTICIPATORY GUIDANCE  [ ] Injury prevention [ ] Family relationships [ ] Other child care providers [ ] Sleep positioning/practices [ ] Talk to baby [ ] Pacifiers, bottle tooth decay [ ] Other  Next scheduled visit  [ ] CRS [ ] WIC [ ] Specialty [ ] Other  Clinician Name  Clinician Signature	LAB/SCREEN	ING	:			27	1 Ves	[ ] No			
[ ] Injury prevention [ ] Family relationships [ ] CRS [ ] Nutrition [ ] Other child care providers [ ] WIC [ ] Sleep positioning/practices [ ] Talk to baby [ ] Specialty	Hct./Hgb.							• •			
Nutrition   Other child care providers   WIC   Sleep positioning/practices   Talk to baby   Specialty   Other     Fever education   Pacifiers, bottle tooth decay   Other     Next scheduled visit   Clinician Name   Clinician Signature	ANTICIPATOR	Y GUIDANCE			RE	ERRALS					
Sleep positioning/practices  [ ] Talk to baby [ ] Fever education  [ ] Pacifiers, bottle tooth decay  [ ] Other  Next scheduled visit  Clinician Name  Clinician Signature		vention									
Pacifiers, bottle tooth decay [ ] Other  Next scheduled visit Clinician Name Clinician Signature		tioning/practices	[ ] Talk to ba	ipà in case bioxideiz		•					
					ן בי						
Was this claim coded as an EPSDT Visit (HCFA-1500)? [ ] Yes [ ] No	Next scheduled v	risit	Clinician Name	<del></del>	CIt	nician Signature					
	Was this claim co	oded as an EPSDT V	risit (HCFA-1500)?	[ ] Yes	[ ] No						

### Early and Periodic Screening Diagnosis and Treatment TRACKING FORM 4 MONTHS

TO BE FILLE	D IN BY OFFIC	CE STAFF:				
Last Name		First Name	AHCCCS ID		D.O.B.	Age
	<del></del>	·				
Primary Care Prov	rider		Date of Examinat	on	Health Plan Name	
Birth Wt.	Weight	Percentile	Height	Percentile	Head Circumference	Percentile
TO BE FILLED	IN BY PROVID	ER		<u> </u>		
	TIAL/INTERVAL					Т
NUTRITIONAL	ASSESSMENT	[ ] Breast Feeding [ ] Fluoride	[ ] Formula		t 3 oaks	P
SENSORY ASSI		[ ] Fluoride ion: Within normal lim uring: Within normal lim		Yes [j]	ron [ ] Solid: No, Refer No, Refer	R
Babble	TAL ASSESSMENT and coos, when	NT Age appropriate?  n prone-holds head erect uspicious, do specific obje	[ ] and raises body or	Yes [] l n hands, rolls ove	No er from prone to supir	ie, grasps rattle,
PHYSICAL EXA			ASSESSMENT &			
Are the following		COMMENTS,	ADDITIONE IN L. O.	rlain —————————		
	~	No .		.•		
Skin						
Head						
Eyes (red reflex)						
Ears ( symmetri	cal)					
Nose						
Mouth/Throat			•			
Nodes						•
Heart						
Lungs						
Abdomen						
Fem. Pulse						
Ext. Gen.						
Hip Abduc.						
Extremities						
Spine						
Neuro		Faller	ad?			Ver I 1 No
Other		Follow-up need			( )	Yes [] No
LAB/SCREENI	NG		DN ASSESSMEN			
Hct./Hgb.			eceive all immuni at immunization :			Yes [] No Yes [] No
ANTICIPATOR	V CHIDANICI			Dr.	-FODAL 6	
ANTICIPATOR	GOIDANCE			ME	ERRALS	
[ ] Injury prev	vention	[ ] Sleep pos		11.	CRS	
[ ] Choking, a		[ ] Thumb s	ucking	įį	WIC	
[ ] Teething [ ] Solid foods		Baby-pro		Helens   [ ]	Specialty	
Г 1 20ПС 100С	•	[ ] Appropri	ate child care prov	ruers L.	) Other	
Next scheduled v	isit	Clinician Name		Clin	nician Signature	
Was this claim co	ded as an EPSDT V	/isit (HCFA-1500)?	[ ] Yes	[ ] No	•	

NO.949 P.6

### Early and Periodic Screening Diagnosis and Treatment FRACKING FORM 6 MONTHS

TO BE FILLED IN	BY OFFI	CE STA	FF:	<del></del>	<del></del>		
Last Name		First N	me	AHCCCS ID		D.O.B.	Age
Primary Care Provider				Date of Examinat	lon	Health Plan Name	
Birth Wt. Weig	ght	Percent	ile	Height	Percentile	Head Circumference	Percentile
TO BE FILLED IN B	Y PROVID	ER					
HISTORY INITIAL Comments	/INTERVA	L				•	r
NUTRITIONAL ASS	ESSMENT	[]	Breast Feeding	[ ] Formula	(type)	·	P
SENSORY ASSESSM DEVELOPMENTAL	He ASSESSME	ion: Waring/Sp NT Age	Fluoride Vithin normal lim eech: Within nor e appropriate?	[ ] Vitamins its? [ ] mal limits? [ ]	Yes [ ] Yes [ ] Yes [ ]	iron [ ] Solids No, Refer No, Refer No	R
Vocalizes sizes to hand. (If	ngle consor	nants, "d , do spec	lada", rolls over, n ific objective testi	o head lag when ng) Assessment T	pulled to sit, si ool (name)	ts with support, transfers	small objects hand
PHYSICAL EXAM			COMMENTS, A	SSESSMENT &	PLAN		
Are the following no	rmal?						
	Yes	No	,	٠			
Skin							
Head						•	
Eyes							
ENT					•		
Teeth							
Nodes		[					
Heart The Heart							
Lungs							
Abdomen							
Ext. Gen.							•
Extremities							
Spine/Neuro							
LAB/SCREENING							
Hgb. or Hct.				•	•		
4" 1938 1971 1980 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	High	Low	Follow-up needs	ud?		r 1	Ver f 3 No
Lead Screen: Verbal Ris	ik			N ASSESSMENT		<u> </u>	Yes [] No
. a b y d Lumpe base ( ) we to see 1944 and 1944 and 1944 and 1944 all 1944	*****						
				ceive all immuni t immunization r			Yes [] No Yes [] No
	<del></del> -		13 CTELES CITIES	r minimumzation i	ecora in the m	edical charts [ ]	18 [] 10
ANTICIPATORY GU	IDANCE				R	EFERRALS	
[ ] Injury preventic [ ] Cup, finger food [ ] No bottle in bed [ ] Pool & tub safet	ds d		[ ] Teething [ ] Poisons - [ ] Nutrition [ ] Sleep posi	-	]	CRS WIC Specialty Other	
Next scheduled visit			Clinician Name	· · · · · · · · · · · · · · · · · · ·	c	linician Signature	
Was this claim coded as	s an EPSDT V	Visit (HCF	A-1500)7	[ ] Yes	[ ] No		



JUN.11.2001 4:25PM

## Early and Periodic Screening Diagnosis and Treatment TRACKING FORM 9 MONTHS

TO BE FILLE	D IN BY OFFIC	E STAFF:				
Last Name		First Name	AHCCCS ID		D.O.B.	AGE
	•					
Primary Care Prov	vider		Date of Examinati	on	Health Plan Name	<u></u>
	,					
Birth Wt.	Weight	Percentile	Height	Percentile	Head Circumference	Percentile
TO BE EILLED	IN BY PROVID	Vn				1
	TIAL/INTERVAL					
Comments		•				T
NUTRITIONAL	. ASSESSMENT	Breast Feeding [	1 Farmula (			P
ı	Supplements:	[ ] Fluoride [	] Vitamins	lron	[ ] Whole Milk	,
SENSORY ASSE		on: Within normal limi	its?	Yes [] 1	No, Refer	R
DEVELOPMEN	TAL ASSESSME	ring/Speech: Within nor. NT Age appropriate?	r i	Voc (1)	No, Refer No	
Respon	ids to own name	understands a few words	s. "no-no" "hve hy	70" . TO 257 6277 "AT		ically, crawls, sits
maepe	ndently, may pu	II to stand (If suspicious, o	do specific objecti	ve testing) Asses	sment Tool (name)	7,
PHYSICAL EXA	AM.	COMMENTS A	SSESSMENT & I	PLAN		
Are the following	ng normal?					
	Yes	No ,				
Skin						
Head			•			
Eyes						
ENT	**************					
Teeth					•	
Nodes				•		
Heart						
Lungs						
Abdomen						
Ext. Gen.						
Extremities					-	
Spine/Neuro						
LAB/SCRLENIN	V Cs					
Hgb./Hct.	)			•		
Lead Screen: Verb	High L	Follow-up neede	d?		[ ] Yes	. [ ] No
rear actest: Asi		IMMUNIZATIO	N ASSESSMENT		, , , , ,	, [ ] 145
Lab Lead Screen	Yes 1	No II	cive all immuniza	ations due today	) . I Var	f l No
DAN DESG SCIENT		Lis there a current	immunization re	cord in the medi	cal chart? [ ] Yes	
ANTICIPATORY	CUIDANCE					
				REF	ERRALS	
[ ] Injury preve [ ] Good paren	ting practices	[ ] Talk to chi [ ] Self-feedin		[1]	CRS	
Baby-proof	home, pool	[ ] Sleep pract			WIC	
[ ] Nutrition					Specialty	
March agh a 31-3 - 3	**					
Next scheduled visi	Ιτ	Clinician Name		Clini	cian Signature	
Was this claim cod	ed as an Engineer					
nm cam cod	en er au erzhi Az	SIT (HCFA-1500)?	[ ] Yes	[ ] No		

### Early and Periodic Screening Diagnosis and Treatment TRACKING FORM 12 MONTHS

TO BE FILLE	DINB	Y OFF	ICE S	TAFF:			· · · · · · · · · · · · · · · · · · ·		·
Last Name			Flo	t Name	AHCCCS ID	· · · · · · · · · · · · · · · · · · ·	D.O.B.		Age
					1				
Primary Care Prov	vider				Date of Examin	nation	Health Plan	Name	<del></del>
Birth Wt.	Weight		Perc	entile	Height	Percentile	Head Circum	rference	Percentile
	<u> </u>						!		
TO BE FILLED								~	
HISTORY INI Comments	TIAL/II	VIERV	AL						T
NUTRITIONAL				Breast Feeding [		ype)		Whole Milk	P
SENSORY ASSI	Suppi ESSMEN		lsion:	Within normal lin		[] Iron ] Yes [	] No, Refer	Solids	R
DEVELOPMEN	TTAT AC			/Speech: Within no Age appropriate?			No, Refer		<u> </u>
Cruise	s, may t	ake a fe	w step	s alone, plays social	.games, peek-a-l	ooo, precise pino		from a cup.	
(If sus	piclous,	do spec	do offic	jective testing) Ass	essment Tool (n	ame)			
PHYSICAL EXA	ΔM			COMMENTS	ASSESSMENT	& PLAN			
Are the following		1217		COMMENTS,	A 3 C 3 MICI VI	GILAN			
1-1 111 1010		Yes	No	11					
Skin				]					
Head				-					
Eyes				]] }		•			•
ENT					•				
Teeth	***************************************								
Nodes				}}}					
Heart									
Lungs									
Abdomen			· .						
Ext. Gen.									
Extremities									
Spine/Neuro									
LAB/SCREENI	NC								
300mm 22.003 0.000 pp 10 0 0 0 0 1 1 1 1 1 1 1 1 1 1 1		High	Low						
Lead Screen: Verb	oal Risk			Follow-up need	led?	-		riv	es [] No
-		Yes	No	11	ON ASSESSME	NI C	•		<u> </u>
Lab Lead Screen	(Despited H and					nizations due to	adarr?	ר ז ע	es [] No
Tuberculin Test						n record in the		[ ] Y [ ] Y	es [] No
ANTICIPATOR	Y GUID	ANCE					REFERRALS		
[ ] Injury pre	vention			[ ] Talk to 8	name objects	ļ	[ ] CRS		
[ ] Good pare		ractices	}	[ ] Dental h	ygiene		[ ] WIC		
[ ] Nutrition [ ] Discipline,	praise			[ ] Sleep pra	caces		[ ] Specialty _		
Next scheduled v	isit			Clinician Name	!		Clinician Signatur	e	
Was this claim co	ded as an	a EPSDT	Visit (	HCFA-1500)?	Yes	No	<del> </del>		

### Early and Periodic Screening Diagnosis and Treatment TRACKING FORM 15 MONTHS

TO BE FILLED IN	BY OF	FICE S	TAFF:			· · · · · · · · · · · · · · · · · · ·					
Last Name			st Name	· · · · · · · · · · · · · · · · · · ·		AHCCCS ID			D.O.B.		Age (Months)
					-						,
Date of Examination	Ht. (in)		Percent	ile	W	L(lbs)	Percentile	Head Cir	rc. (cm)	Health Plan Na	me
TO BE FILLED IN BY	PROV	IDER								· · · · · · · · · · · · · · · · · · ·	
HISTORY INITIAL/			• ,	•							т
Comments											P
NUTRITIONAL ASSE	SSMEN	rı	1 Breast	Feeding	ſ	1 Whole M	ווא נז מו	m r 1	Rottle	[ ] Table Fe	
լ . օսթբ	rement	2:	] Finor	ade	l	Vitamin	מט נין כם ג	[] []		[ ] TADLE TO	R
SENSORY ASSESSME		/ision:		normal l		ts?	] Yes	_	lo, Refer		
DEVELOPMENTAL A	SSESSA	ÆNT	Age app	ropriate?		ī	1 Ves	f 1 N	io, Refer		
Three to six	words,	points	to one or	more boo	dy į	arts, underst	ands simple	comman	ds walks	well, climbs s	tairs, feeds self
with fingers, 1	ustens t	to a sto	ry. (If su	spicious,	do :	specific objec	tive testing)	Assessme	ent Tool	(name)	
PHYSICAL EXAM			CON	AMENTS	A	SSESSMENT	& PLAN				
Are the following nor	nal?				, , .						
<b>.</b>	Yes	No	,								
Skin	<u></u>	ļ									
HEENT	,,										
Teeth											
Nodes											
Heart									•		
Lungs											
Abdomen											
Ext. Gen.											
Extremities	1										•
Spine/Neuro											
LAB/SCREENING											•
Tuberculin Test			Follo	w-up nee	ded	?				. [] Y	es [] No
redd oppgresi mae goddy'r brill o dillag agg polengagagan py y bann godd	High	Low				I ASSESSME					
Lead Screen: Verbal Risk			ls the	this child ere a curr	rec ent	eive all immu immunizatio	nizations du n record in t	e today? he medic	al chart?	[ ] Y ' [ ] Y	~ -
ANTICIPATORY GUID	ANCE		J \							. , -	
									RRALS		
[ ] Injury prevention [ ] Good parenting pr	actices			Discipling Sleep pr					Dental (I CRS	Baby bottle too	th decay)
[ ] Tantrums				Nutritio		ÇES		Įį į	WIC		
[ ] Eating			[ ]	Other					Specialty Other	<del></del>	<del></del>
Next scheduled visit			Clin	ician Nam	e				ian Signat	ture	
Was this claim coded as an	EPSDT	Visit (H	CFA-1500)	)?		[ ] Yes	[ ] No		·		·

### Early and Periodic Screening Diagnosis and Treatment TRACKING FORM 18 MONTHS

TO BE FILLED IN BY OFFICE STA	FF:									
Last Name First N	lame	AHCCC3 ID			D.O.B.			Ag	ge (Mar	ths)
			72	1.0	(==)	Health !	Diam \$7-			
Date of Examination Ht. (in)	Percentile	Wt.(Ibs)	Percentile	Head C	rc. (cm)	Hezith .	Plan Na	me		
TO BE FILLED IN BY PROVIDER									т	
HISTORY INTTIAL/INTERVAL Comments		•						ĺ		
•				_		, _			P	
NUTRITIONAL ASSESSMENT [ ] Supplements: [ ]		[ ] Whole N		Cnb		ible Food	15		R	
SENSORY ASSESSMENT Vision:	Within normal li	mits?	[ ] Yes	[ ]	No, Refe			,		
Hearing/S DEVELOPMENTAL ASSESSMENT A	peech: Within no		[] Yes [] Yes		No, Refe No	•				
15 to 20 words, some two wo	rd phrases, runs s	tiffly, walks ba	ckwards, thr	ows a bal		poon an	d cup.			
(If suspicious, do specific obje	ctive testing) As	sessment Tool	(name)			<u>,</u>				
PHYSICAL EXAM	COMMENTS	ASSESSMEN	T & PLAN							
Are the following normal?										
Yes No			•							
Sidn										
HEENT						•				
Teeth										
Nodes					•					
Heart										
Lungs		•								
Abdomen										
Ext. Gen.		•								
Extremities									,	
Spine/Neuro										
LAB/SCREENING									•	
Tuberculin Test	Follow-up nee	eded?					[]	Yes	[ ]	No
High Low	IMMUNIZAT	ION ASSESSI	MENT							
Lead Screen: Verbal Risk	Did this child Is there a curr					. <b>→</b> ?	[ ]	Yes Yes	[]	No No
	IS there a corr	ent minutesa	don record n	d die me	CIICAI CIIA		6 1	163		
ANTICIPATORY GUIDANCE				RE	FLRRAL	2				
[ ] Injury prevention		interaction			Denta CRS	I				
Discipline/limits     Good parenting practices	[ ] Mealtin	nes raining			) WIC	1÷				
[ ] Sleep practices	[ ] Read to			Įţ	] Special Other					
Next scheduled visit	Clinician Nan	ne		CI	nician Sig	mature				
Was this claim coded as an EPSDT Visit (H	CFA-1500)?	[ ] Yés	[ ]	No						

# Early and Periodic Screening Diagnosis and Treatment TRACKING FORM 24 MONTHS

TO BE FILLED IN I	BY OF	FICE S	TAFF:						· · · · · · · · · · · · · · · · · · ·
Last Name		Firs	t Name	AHCCCS ID	<del></del>		D.O.B.	· · · · · · · · · · · · · · · · · · ·	Age (Months)
							ļ		
Date of Examination 1	Ht. (in)		Percentile	Wt.(lbs)	Percentile	Head Ci	rc. (cm)	Health Plan Nan	ne
TO BE FILLED IN BY	PROVI	DER							
HISTORY INITIAL/I									Т
Comments ·	- 1			,					
								,	P
NUTRITIONAL ASSES		•	-	[ ] Inadequate					R
SENSORY ASSESSMEN			Within normal li Within normal li		-		No, Refer		
		_	Within normal li	-	•		No, Refer No, Refer	•	
DEVELOPMENTAL AS				•	] Yes		Vo	, <del>-</del>	
At least 20 wo	ords, kie	k a ball	l, can follow two-	step commands,				five or six block	ks
(If suspicious,	qo zbe	cific ob	jective testing) A	ssessment Tool (1	name)			·	
DUNCICAL EVAL									
PHYSICAL EXAM			COMMENTS	, ASSESSMENT	& PLAN				
Are the following nom	nal? Yes	No							
Skin	163	140	1						
HEENT	·								
***************************************									
Teeth									
Nodes								2	•
Heart									
Lungs		1 _						•	
Abdomen			<b>  }                                   </b>				٠		
Ext. Gen.									
Extremities									
Spine/Neuro	<u> </u>			•					
LAB/SCREENING									
Tuberculin Test				<u>L</u>					
and harden and the relation of the same and the relation of th	322	7.0=:							•
Lead Screen: Verbal Risk	High	Low	Follow-up ne	eded?				[ ] Y	es [] No
read actects; Actual Kizk	<del>  ,,</del>	33.	IMMUNIZAT	TION ASSESSM	ENT				
	Yes	No	Did this child	receive all imm	unizations de	ze today	?	[] Y	es [] No
Lab Lead Screen (required)			Is there a cur	ent immunizatio	on record in 1	the medi	ical chart	? [jy	es [ ] No
ANTICIPATORY GUID	ANCE					REE	ERRALS		
			<del></del>		<del>,                                    </del>				
[ ] Changes in appeti [ ] Brushing teeth	te		[ ] Injury ; [ ] Nutrition	prevention			Dental CRS		
[ ] Read to child	•	•	[ ] Sleep p	ractices		[ ]	WIC	· <del>-</del>	
[ ] Toilet training			[ ] Child c	are providers			Specialt Other	y <del></del>	
Next scheduled visit	<del></del>		Clinician Nan	·		Clim	ician Sign:	eture	
				<del></del>		- Lun	resert mRt)	ient e	
Was this claim coded as as	n EPSDT	Visit (H	(CFA-1500)7	[ ] Yes	[ ] No	<del></del> )			

### Early and Periodic Screening Diagnosis and Treatment TRACKING FORM 3 YEARS

TO BE FILLED IN E	Y OFF	ICE S	CAFF	:		<del></del>								
Last Name		Firs	Nam	le	AHCCCS ID	· · · · · · · · · · · · · · · · · · ·		D.O.B.			1	Age (	(ears)	)
											ļ			
Date of Examination 1	It. (in)		Per	centile	Wt.(lbs)	Percentile		B.P.	Healt	h Pla	n Nan	ae		
					•									
TO BE FILLED IN BY	PROVI	DER										=	=	
HISTORY INTITAL/I	NTERV	AT.										T		.
Comments	,	_			•									
NUTRITIONAL ASSES	SMENT	· r	1 4	dequate [	] Inadequate	r 1 Bafa						P.		
SENSORY ASSESSMEN	VI Vi	sion:	With	in normal li	mits?	: [] Refe		o, Refer				R		
				un normal lir un normal lir		] Yes		, Refer						
DEVELOPMENTAL AS	SESSM	ENT A	Age a	ppropriate?	ĺ	î Yes	ΪÌΝα	o, Refer			_			
Jumps in place	e, balan	ces on	one i	foot, rides a t	ricycle, knows	wn name, age,	sex, con	pies a circl	e and	a cro	ss.			
BEHAVIORAL HEALT	H ASSE	SSMEN	π	Referral ind	sessment Tool ( licated?	Yes	[ ] No	<u> </u>	<del></del>					
Tool used: (Pediatric Sy	mptom	Check	dist,	parental inter	rview, observati	on, etc.)								
DUVCV AL CYANA														
PHYSICAL EXAM	-10			OMMENIS	, ASSESSMEN	& PLAN								
Are the following nom	nai? Yes	No		•										
Skin		1,10		•										
HEENT	<del></del>											•		
tone had the terrest of the second second had been been dependent														
Teeth														
Nodes				•										
Heart														
Lungs								٠						
Abdomen														
Ext. Gen.														
Extremities			-		•									
Spine/Neuro					,		•							
LAB/SCREENING														
Tuberculin Test			F	ollow-up nee	ded?				. 1	[ ]	Yes	[	] N	<b>To</b>
	High	Low			ION ASSESSM									
Lead Screen: Verbal Risk						unizations due on record in the		al chart?	į		Yes Yes	[	_	ic io
	<del></del>					on record in the	- mean					<u>.</u>		
ANTICIPATORY GUID	ANCE						REFE	RRALS						
[ ] Injury prevention [ ] Good parenting pr [ ] Toilet training [ ] Discipline	ractices		٠	[ ] Dental ( [ ] Nutritio [ ] Sexual (	n.			Dental Jehavioral I JES VIC Pecialty Other	Health .	···-				
Next scheduled visit		··- <u></u>		Clinician Nam	ıe	······································	Clinic	ian Signatu	re .					
Was this claim coded as ar	a EPSDT	Visit (H	CFA-1	1500)?	[ ] Yes	[ ] No	1			<del></del>				

### Early and Periodic Screening Diagnosis and Treatment TRACKING FORM 4 YEARS

Last Name First Name AACCCS ID D.O.B. AGE (Vean)  Date of Examination RL (in) Percentile Wt.(lbs) Percentile B.Z. Health Flan Name  TO BE STILED IN BY PROVIDER HISTORY FURITAL/INTERVAL Comments  NUTRITIONAL ASSESSMENT [ ] Adequate [ ] Inadequate [ ] Referred SENSORY SCREEN VIsion: Within normal limits? [ ] Yes [ ] No, Refer Rearing: Within normal limits? [ ] Yes [ ] No, Refer DEVELOPMENTAL ASSESSMENT Age appropriate? [ ] Yes [ ] No Refer DEVELOPMENTAL ASSESSMENT Age appropriate? [ ] Yes [ ] No Can sing a song, dows a person with inter parts, gives first and last name. (If suspicious, do specific objective testing) Assessment Tool (name) BEHAVIORAL FEALTH ASSESSMENT Regrand indicated? [ ] Yes [ ] No Tool used. (Pediatric Symptom Checklist, parental laterview, discretation, etc.)  PHYSICAL EXAM Are the following normal?  FREENT	TO BE FILLED IN	BY OFFICE ST	TAFF:			·		
TO BE FILLED IN SY PROVIDER HISTORY INITIAL/INITERVAL Comments  NUTRITIONAL ASSESSMENT [ ] Adequate [ ] Inadequate [ ] No, Refer SENSORY SCREEN Vision: Within normal limits? [ ] Yes [ ] No, Refer Rearing: Within normal limits? [ ] Yes [ ] No, Refer Rearing: Within normal limits? [ ] Yes [ ] No, Refer Rearing: Within normal limits? [ ] Yes [ ] No, Refer Rearing: Within normal limits? [ ] Yes [ ] No, Refer Rearing: Within normal limits? [ ] Yes [ ] No, Refer Rearing: Within normal limits? [ ] Yes [ ] No, Refer Rearing: Within normal limits? [ ] Yes [ ] No, Refer Rearing: Rearing: Refer Refer Refer Refer Rearing: Refer				AHCCCS ID		D.O.B.		Age (Years)
TO BE FILLED IN SY PROVIDER HISTORY INITIAL/INITERVAL Comments  NUTRITIONAL ASSESSMENT [ ] Adequate [ ] Inadequate [ ] No, Refer SENSORY SCREEN Vision: Within normal limits? [ ] Yes [ ] No, Refer Rearing: Within normal limits? [ ] Yes [ ] No, Refer Rearing: Within normal limits? [ ] Yes [ ] No, Refer Rearing: Within normal limits? [ ] Yes [ ] No, Refer Rearing: Within normal limits? [ ] Yes [ ] No, Refer Rearing: Within normal limits? [ ] Yes [ ] No, Refer Rearing: Within normal limits? [ ] Yes [ ] No, Refer Rearing: Within normal limits? [ ] Yes [ ] No, Refer Rearing: Rearing: Refer Refer Refer Refer Rearing: Refer								
TO BE FILLED IN BY PROVIDER HISTORY DUTIAL/INTERVAL Comments  Within normal limits? [] Yes [] No, Refer SENSORY SCREEN Vision: Within normal limits? [] Yes [] No, Refer SENSORY SCREEN Vision: Within normal limits? [] Yes [] No, Refer Sensory Screen Vision: Within normal limits? [] Yes [] No, Refer Sensory Screen Vision: Within normal limits? [] Yes [] No, Refer Sensory Screen Vision: Within normal limits? [] Yes [] No, Refer Sensory Screen Vision: Within normal limits? [] Yes [] No, Refer Sensory Screen Vision: Within normal limits? [] Yes [] No, Refer Sensory Screen Vision: Within normal limits? [] Yes [] No Refer R  PHYSICAL EXAM Are the following normal? Yes No Skin REENT [] No Skin REENT [] No Skin REENT [] No Skin RETER [] No Skin [] No	Date of Examination	Ht. (in)	Percentile	Wt.(lbs)	Percentile	B.P.	Health Plan N	ame
HISTORY INITIAL/INTERVAL Comments  NUTRITIONAL ASSESSMENT [ ] Adequate [ ] Inadequate [ ] Referred SENSORY SCREEN Vision: Within normal limits? [ ] Ye. [ ] No, Refer Rearing Within normal limits? [ ] Ye. [ ] No, Refer Speech: Within normal limits? [ ] Ye. [ ] No, Refer Can sing a song, draws a person with three parts, gives first and last name. (If suspicious, do specific objective testing) Assessment Tool (name). (If suspicious, do specific objective testing) Assessment Tool (name). (If suspicious, do specific objective testing) Assessment Tool (name). (If suspicious, do specific objective testing) Assessment Tool (name). (If suspicious, do specific objective testing) Assessment Tool (name). (If suspicious, do specific objective testing) Assessment Tool (name). (If suspicious, do specific objective testing) Assessment Tool (name). (If suspicious, do specific objective testing) Assessment Tool (name). (If suspicious, do specific objective testing) Assessment Tool (name). (If suspicious, do specific objective testing) Assessment Tool (name). (If suspicious, do specific objective testing) Assessment Tool (name).  COMMENTS, ASSESSMENT & FLAN  Abdomen  Ext. Gen.  Extremities  Spine/Neuro  Lads/SCREENING  Rablerals  [ ] Yes [ ] No  Minumization Assessment  [ ] No High Low  Lads/SCREENING  Rablerals  [ ] Yes [ ] No  ANTICIPATORY GUIDANCE  [ ] Injury prevention  [ ] Injury prevention [ ] Injury prevention [ ] Dental care [ ] Dental care [ ] Dental care [ ] Jensenting practices [ ] Discipline [ ] Good parenting practices [ ] Discipline [ ] Secual cutlosity [ ] Preschool [ ] Secual cutlosity [ ] Objective testing and the security of the se			54					
HISTORY INITIAL/INTERVAL Comments  NUTRITIONAL ASSESSMENT [ ] Adequate [ ] Inadequate [ ] Referred SENSORY SCREEN Vision: Within normal limits? [ ] Ye. [ ] No, Refer Rearing Within normal limits? [ ] Ye. [ ] No, Refer Speech: Within normal limits? [ ] Ye. [ ] No, Refer Can sing a song, draws a person with three parts, gives first and last name. (If suspicious, do specific objective testing) Assessment Tool (name). (If suspicious, do specific objective testing) Assessment Tool (name). (If suspicious, do specific objective testing) Assessment Tool (name). (If suspicious, do specific objective testing) Assessment Tool (name). (If suspicious, do specific objective testing) Assessment Tool (name). (If suspicious, do specific objective testing) Assessment Tool (name). (If suspicious, do specific objective testing) Assessment Tool (name). (If suspicious, do specific objective testing) Assessment Tool (name). (If suspicious, do specific objective testing) Assessment Tool (name). (If suspicious, do specific objective testing) Assessment Tool (name). (If suspicious, do specific objective testing) Assessment Tool (name).  COMMENTS, ASSESSMENT & FLAN  Abdomen  Ext. Gen.  Extremities  Spine/Neuro  Lads/SCREENING  Rablerals  [ ] Yes [ ] No  Minumization Assessment  [ ] No High Low  Lads/SCREENING  Rablerals  [ ] Yes [ ] No  ANTICIPATORY GUIDANCE  [ ] Injury prevention  [ ] Injury prevention [ ] Injury prevention [ ] Dental care [ ] Dental care [ ] Dental care [ ] Jensenting practices [ ] Discipline [ ] Good parenting practices [ ] Discipline [ ] Secual cutlosity [ ] Preschool [ ] Secual cutlosity [ ] Objective testing and the security of the se	TO BE FILLED IN B	Y PROVIDER						
NUTRITIONAL ASSESSMENT [] Adequate [] Inadequate [] Referred  SENSORY SCREEN Vision: Within normal limits? [] Yes [] No, Refer  Hearing: Within normal limits? [] Yes [] No, Refer  Besting: Within normal limits? [] Yes [] No, Refer  DEVELOPMENTAL ASSESSMENT Age appropriate? [] Yes [] No, Refer  DEVELOPMENTAL ASSESSMENT Age appropriate? [] Yes [] No Refer  Can sing a song, draws a person with three parts, gives first and last name.  (If suspicious, do specific objective testing) Assessment Tool (name)  BEHAVIORAL PREALTH ASSESSMENT Referral indicated? [] Yes [] No  Tool used: (Pediatric Symptom Checklist, parental interview, observation, etc.)  PHYSICAL EXAM  Are the following normal?  Yes No  Skin			•	•			•	Τ
SENSORY SCREEN Vision: Within normal limits?   Yes   No, Refer   R	Comments	•						
SENSORY SCREEN Vision: Within normal limits?	NITTRITIONAL ASS	ESCMENT I	1 Adequate	[ ] Imadeouste	[ ] Defe	mad		P
Hearing: Within normal limits?		Vision:	Within normal I					<b>.</b>
DEVELOPMENTAL ASSESSMENT Age appropriate?  Can sing a song, draws a person with three parts, gives first and last name.  (If suspicious, do specific objective testing) Assessment Tool (name).  BEHAVIORAL HEALTH ASSESSMENT Referral indicated? [] Yes [] No  Tool used: (Pediatric Symptom Checklist, parental interview, observation, etc.)  PHYSICAL EXAM  Are the following normal?  Yes No  Skin		Hearing	: Within normal I	imits?	] Yes [	] No, Refer		K
Can sing a song, draws a person with three parts, gives first and last name.  (If stspicious, do specific objective testing). Assessment Tool (name)  BEHAVIORAL HEALTH ASSESSMENT Referral indicated? [ ] Yes [ ] No  Tool used: (Pediatric Symptom Checklist, parental interview, observation, etc.)  PHYSICAL EXAM  Are the following normal?  Yes No  Skin	DEVELOPMENTAL	Speech:	Within normal	limits? [				
(If suspicious, do specific objective testing) Assessment Tool (name) BEHAVIORAL HEALTH ASSESSMENT Referral indicated? [] Yes [] No Tool used: (Pediatric Symptom Checklist, parental interview, observation, etc.)  PHYSICAL EXAM  Are the following normal?  Yes No Skin						1 140	-	•
Tool used: (Pediatric Symptom Checklist, parental interview, observation, etc.)  PHYSICAL EXAM Are the following normal? Yes No Skin  HEENT Teeth Nodes Heart Lungs Abdomen Ext. Gen. Extremities Spine/Neuro LAB/SCREENING Tuberculin Test High Low Land Screen: Verbal Risk  High Low Information To be a current immunization due today? If yes [] No Skin  Information Test Information	(If suspiciou	is, do specific ob	jective testing) A	ssessment Tool (	name)			
Are the following normal?  Yes No Skin						] No		
Are the following normal?  Yes No Skin	1001 used: (Fediatric	symptom Chec	klist, parentai inti	erview, observati	on, etc.)	····		· · · · · · · · · · · · · · · · · · ·
Are the following normal?  Yes No Skin	DHVSICAL EXAM		COMPAGNE	ACCECCAENT	S 01-4-1			
Skin		12	COMMENTS	WEINIGGE CONTRACT	& PLAIN			
Skin   HEENT	Are the following no							
HEENT	Clrim	IES NO				•		•
Teeth Nodes Heart Lungs Abdomen Ext. Gen. Extremities Spine/Neuro  LAB/SCREENING Tuberculin Test High Low Lead Screen: Verbal Risk  Follow-up needed?  IMMUNIZATION ASSESSMENT Did this child receive all immunizations due today? [] Yes [] No  ANTICIPATORY GUIDANCE  [] Injury prevention [] Good parenting practices [] Injury prevention [] Good parenting practices [] Injury prevention [] Joint training [] Dental are [] Dental Security [] Preschool  [] Security [] Other  Next scheduled visit  Clinician Name  Clinician Signature	TALL)		11					·
Nodes Heart Lungs Abdomen Ext. Gen. Extremities Spine/Neuro  LAB/SCREENING Tuberculin Test High Low High Low Laad Screen: Verbal Risk  Laad Screen: Verbal Risk  Laad Screen: Verbal Risk  Follow-up needed?  IMMUNIZATION ASSESSMENT Did this child receive all immunizations due today? [] Yes [] No ANTICIPATORY GUIDANCE  [] Injury prevention [] Good parenting practices [] Injury prevention [] Good parenting practices [] Dental care [] Dental care [] Dental care [] Sexual curiosity  [] Preschool  Cinician Name  Clinician Signature	HEENT		11					•
Heart  Lungs Abdomen  Ext. Gen.  Extremities  Spine/Neuro  LAB/SCREENING  Tuberculin Test  High Low  High Low  Lead Screen: Verbal Risk  Lead Screen: Verbal Risk  Did this child receive all immunizations due today? [] Yes [] No  ANTICIPATORY GUIDANCE  [] Injury prevention [] Good parenting practices [] Injury prevention [] Good parenting practices [] Tollet training [] Dental care [] Dental care [] Sexual curiosity [] Preschool  Next scheduled visit  Clinician Name  Clinician Signature	Teeth		1					
Heart  Lungs Abdomen  Ext. Gen.  Extremities  Spine/Neuro  LAB/SCREENING  Tuberculin Test  High Low  High Low  Lead Screen: Verbal Risk  Lead Screen: Verbal Risk  Did this child receive all immunizations due today? [] Yes [] No  ANTICIPATORY GUIDANCE  [] Injury prevention [] Good parenting practices [] Injury prevention [] Good parenting practices [] Tollet training [] Dental care [] Dental care [] Sexual curiosity [] Preschool  Next scheduled visit  Clinician Name  Clinician Signature	544444							
Lungs Abdomen  Ext. Gen.  Extremities  Spine/Neuro  LAB/SCREENING  Tuberculin Test  High Low  Lead Screen: Verbal Risk  Did this child receive all immunizations due today? [] Yes [] No  In MUNIZATION ASSESSMENT  Did this child receive all immunizations due today? [] Yes [] No  ANTICIPATORY GUIDANCE  [] Injury prevention [] Good parenting practices [] Discipline [] Gental care [] Discipline [] CRS [] Toilet training [] Dental care [] WIC [] Sexual curiosity  Clinician Name  Clinician Signature	Nodes						•	
Abdomen   Ext. Gen.   Extremities   Spine/Neuro   LAB/SCREENING   Tuberculin Test   Follow-up needed?   [ ] Yes [ ] No   IMMUNIZATION ASSESSMENT   Did this child receive all immunizations due today?   [ ] Yes [ ] No   Is there a current immunization record in the medical chart?   [ ] Yes [ ] No   No   Impury prevention   [ ] Injury prevention   [ ] Dental care   [ ] Dental care   [ ] Dental care   [ ] Specialty   [ ] Other   Next scheduled visit   Clinician Name   Clinician Signature	Heart		<b> </b>  -					
Abdomen   Ext. Gen.   Extremities   Spine/Neuro   LAB/SCREENING   Tuberculin Test   Follow-up needed?   [ ] Yes [ ] No   IMMUNIZATION ASSESSMENT   Did this child receive all immunizations due today?   [ ] Yes [ ] No   Is there a current immunization record in the medical chart?   [ ] Yes [ ] No   No   Impury prevention   [ ] Injury prevention   [ ] Dental care   [ ] Dental care   [ ] Dental care   [ ] Specialty   [ ] Other   Next scheduled visit   Clinician Name   Clinician Signature	Lungs							
Ext. Gen.  Extremities  Spine/Neuro  LAB/SCREENING  Tuberculin Test  High Low  Lead Screen: Verbal Risk  Lead Screen: Verbal Risk  Lead Screen: Verbal Risk  Lead Screen: Verbal Risk  Injury prevention  [ ] Nutrition [ ] Good parenting practices [ ] Injury prevention [ ] Toilet training [ ] Dental care [ ] Dental care [ ] Dental care [ ] Secual curlosity  [ ] Preschool  Clinician Name  Clinician Signature								
Extremities  Spine/Neuro  LAB/SCREENING  Tuberculin Test  High Low  Laad Screen: Verbal Risk  Laad Screen: Verbal Risk  Did this child receive all immunizations due today? [] Yes [] No Is there a current immunization record in the medical chart? [] Yes [] No ANTICIPATORY GUIDANCE  [] Injury prevention [] Good parenting practices [] Injury prevention [] Joscipline [] CRS [] Wilc [] Preschool [] Sexual curiosity  [] Preschool [] Other  Next scheduled visit    Clinician Name   Clinician Signature	ADGOMEN							
Spine/Neuro  LAB/SCREENING  Tuberculin Test  High Low  High Low  Lead Screen: Verbal Risk  Lead Screen: Verbal Risk  Did this child receive all immunizations due today?  Is there a current immunization record in the medical chart?  [] Yes [] No  ANTICIPATORY GUIDANCE  [] Injury prevention [] Good parenting practices [] Injury prevention [] Good parenting practices [] Dental care [] Dental care [] Dental care [] WIC [] Sexual curiosity  [] Preschool  Clinician Name  Clinician Signature	Ext. Gen.			•				
Tuberculin Test   Follow-up needed?   [ ] Yes [ ] No   IMMUNIZATION ASSESSMENT    Laad Screen: Verbal Risk   Did this child receive all immunizations due today?   [ ] Yes [ ] No   Is there a current immunization record in the medical chart?   [ ] Yes [ ] No    ANTICIPATORY GUIDANCE   REFERRALS    [ ] Injury prevention   [ ] Nutrition   [ ] Dental   [ ] Behavioral Health   [ ] CRS   [ ] WIC   [ ] Specialty   [ ] Specialty   [ ] Other    Next scheduled visit   Clinician Name   Clinician Signature   Clin	Extremities	***		•				
Tuberculin Test   Follow-up needed?   [ ] Yes [ ] No   IMMUNIZATION ASSESSMENT    Laad Screen: Verbal Risk   Did this child receive all immunizations due today?   [ ] Yes [ ] No   Is there a current immunization record in the medical chart?   [ ] Yes [ ] No    ANTICIPATORY GUIDANCE   REFERRALS    [ ] Injury prevention   [ ] Nutrition   [ ] Dental   [ ] Behavioral Health   [ ] CRS   [ ] WIC   [ ] Specialty   [ ] Specialty   [ ] Other    Next scheduled visit   Clinician Name   Clinician Signature   Clin	necessaries reconstitutivities de processories			•				
Tuberculin Test   Follow-up needed?	Spine/Neuro		11					
High   Low   Lead Screen: Verbal Risk   Did this child receive all immunizations due today?	LAB/SCREENING			•			•	
High   Low   Lead Screen: Verbal Risk   Did this child receive all immunizations due today?	Tuberculin Test		Follow-up pe	eded?			[ ] Ye	s I I No
Lead Screen: Verbal Risk  Did this child receive all immunizations due today?  Is there a current immunization record in the medical chart?  REFERRALS  [ ] Injury prevention	Appropriate Proper Street Appropriate Street		I		ENT		, J	
Is there a current immunization record in the medical chart?   Yes   No		High Low	1			roden?	T 1 Ve	e I I No
ANTICIPATORY GUIDANCE  [ ] Injury prevention         [ ] Nutrition         [ ] Behavioral Health         [ ] CRS         [ ] WIC         [ ] Sexual curiosity         [ ] Preschool         [ ] Other  Next scheduled visit  Clinician Name  Clinician Signature	Lead Screen: Verbal Ris	ik						
[ ] Injury prevention [ ] Nutrition [ ] Behavioral Health [ ] Good parenting practices [ ] Discipline [ ] CRS [ ] WIC [ ] Sexual curiosity [ ] Preschool [ ] Specialty [ ] Other  Next scheduled visit   Clinician Name   Clinician Signature								
Injury prevention	ANTICIPATORY GU	IDANCE				REFERRALS		
[ ] Good parenting practices [ ] Discipline [ ] CRS [ ] Toilet training [ ] Dental care [ ] WIC [ ] Sexual curiosity [ ] Preschool [ ] Specialty [ ] Other  Next scheduled visit   Clinician Name   Clinician Signature	[ ] Injury negro-sis		[ ] Mindelal	00			1	
[ ] Toilet training [ ] Dental care [ ] WIC [ ] Sexual curiosity [ ] Preschool [ ] Specialty [ ] Other  Next scheduled visit   Clinician Name   Clinician Signature			• •				neatin	
Next scheduled visit  Clinician Name  Clinician Signature	[ ] Toilet training		[ ] Dental	care		[ ] WIC		
Next scheduled visit Clinician Name Clinician Signature	[ ] Sexual curiosity		[ ] Presche	ool	•	[ ] Specialty _	· · · · · · · · · · · · · · · · · · ·	
	Next scheduled wish		Clinidan No.	me.				
Was this claim coded as an EPSDY Visit (HCTA-1500)?	Sentment ATM		CHILICIAN 1441			-minerati gikirati	a.c	
	Was this claim anded as	an EPCOT Mais C	CEA-1500\2	[ ] Yes	[ ] No	<u> </u>		

# Early and Periodic Screening Diagnosis and Treatment TRACKING FORM 5 YEARS

TO BE FILLED IN E	BY OFFICE S	TAFF:	<del></del>	·	<del></del>		<del></del>
Last Name		. Name	AHCCCS ID	· · · · · · · · · · · · · · · · · · ·	D.O.B.		Age (Years)
·					<u> </u>		
Date of Examination I	Ht. (in)	Percentile	Wt.(lbs)	Percentile	B.P.	Health Plan	Vame -
	<del></del>	LL		<u> </u>			
TO BE FILLED IN BY			ν.				
HISTORY INITIAL/I	NTERVAL						Τ
NUTRITIONAL ASSES	SSMENT [	] Adequate [	] Inadequate	e [ ] Refe	erred		P
SENSORY SCREEN	Vision:	Within normal lin	mits? [	] Yes	[ ] No, Refer		R
	Speech:	: Within normal lis Within normal lis	mits?	] Yes	[ ] No, Refer [ ] No, Refer		
DEVELOPMENTAL A	SSESSMENT	Age appropriate?	[	] Yes	[ ] No		anno lettera
		s own address, can ejective testing) As			lost letters of alp	nabet, prints	some leners.
BEHAVIORAL HEALT	TH ASSESSME	NT Referral ind	licated? [	Yes	[ ] No		
Tool used: (Pediatric S	ymptom Chec	xust, parentai inter	rview, observati	on, etc.)			
PHYSICAL EXAM		COMMENTS	ASSESSMENT	& PLAN			
Are the following nom	nal?						
	Yes No			•	· .		
Skin				•			
HEENT							
Teeth				•	-		
Nodes		11 1					
Heart							•
Lungs	<del>                                     </del>					•	
Abdomen					·		
Ext. Gen.	<del> </del>						
Extremities	-						
Ar 54 1 mand processor bild considerated and table 1000 t photo part cabes	<del>                                     </del>		,				•
Spine/Neuro		[.] [		,			
LAB/SCREENING							
Tuberculin Test		)   Pallana	.119				ha ( 1 No
Urinalysis (Required)		Follow-up nee	ded? ION ASSESSM	IENET		[ ] Y	es [] No
	High Low			unizations due	todan?	רוש	es [] No
Lead Screen: Verbal Risk					today? e medical chart?		es [] No es [] No
ANTIGICATOR	MNG-						
ANTICIPATORY GUIE					REFERRALS		
[ ] Injury prevention [ ] Good parenting p		[ ] Dental (				Health	
[ ] Nutrition		[ ] Discipli	ne .	÷	[ ] CRS		
<ul><li>[ ] Street safety</li><li>[ ] Should know full</li></ul>	name, address	[ ] Househ , and phone numb					· · · · · · · · · · · · · · · · · · ·
Next scheduled visit		Clinician Nam			Clinician Signat	ше	
Was this claim coded as a	n EPSDT Visit (1	ICFA-1500)?	[ ] Yes	[ ] No			

## Early and Periodic Screening Diagnosis and Treatment TRACKING FORM 6 YEARS

TO BE FILLED IN	BY OFFICE S	TAFF:		· · · · · · · · · · · · · · · · · · ·			
Last Name	Firs	t Name	AHCCCS I	D	D.O.B.		Age (Years)
Date of Examination	Ht. (in)	Percentile	Wt.(Ibs)	Percentile	B.P.	Health Plan	Name
TO BE FILLED IN B		•		•			
HISTORY INITIAL	/INTERVAL						T
Comments			•			•	P
NUTRITIONAL ASS	ESSMENT [	] Adequate	[ ] Inadequ	ate [] Re	eferred		*
SENSORY SCREEN		Within normal		[ ] Yes	[ ] No, Refer		R
		: Within normal		[ ] Yes	[ ] No, Refer		
		Within normal		[ ] Yes	[ ] No, Refer		
DEVELOPMENTAL				[ ] Yes	[ ] No	•	
(If suspicious, do spe				Yes	[ ] No		
Tool used: (Pediatric				• •	I 1 140		
	->						
PHYSICAL EXAM		COMMENT	S, ASSESSME	NT & PLAN		·····	
Are the following no	rmal?						
THE DIE YOUGHING THE	Yes No						
Skim		7   '		•			
HEENT		<del> </del>					
******* ****** * *** ***** * *** *** *		11.1					
Teeth						•	
Nodes		111					
Heart		<del>{</del> }} }				•	
	· · · · · · · · · · · · · · · · · · ·	<b>}</b>				•	
Lungs							•
Abdomen		]] [					
Ext. Gen.		1] ]					
Treatment to manage to the committee of the state of the first of the state of the		41 1				•	
Extremities			•				
Spine/Neuro				,			
LAB/SCREENING		11.1					
		511					
Tuberculin Test		11 1				,	
	High Low	Follow-up n				[] ¥	es [] No
Lead Screen: Verbal Ris	k .	IMMUNIZA	TION ASSESS	MENT			
				nmunizations du			es [] No
·		is there a cu	rrent immuniz	ation record in t	he medical chart?	£ ], ¥	es [] No
ANTICIPATORY GU	IDANCE				REFERRALS		
	·				NG EMVA		
[ ] Good health ha	bits	[ ] Safety			[ ] Dental	Uanlah	
Social interactio		[ ] Denta			[ ] Behavioral	THESITO	
[ ] Good parenting [ ] Bicycle helmet	bracnes	[ ] Nutrit	HON		[ ] Specialty		
h . d					Other		
Next scheduled visit		. Clinician Na	me		Clinician Signat	ure	,
Was this claim coded as	an EPSDT Visit (	HCFA-1500)?	[ ] Yes	[ ] No	<del>- 1</del>		

1017.11.4001 4.63FM

NO.949 P.16

# Early and Periodic Screening Diagnosis and Treatment TRACKING FORM 8 YEARS

TO BE FILLED IN	BY OFFICE ST	CAFF:			-	·				
Last Name		Name	1	AHCCCS ID			D.O.B.		·Age (Ye	ars)
								I	<b>!</b>	
Date of Examination	Ht (in)	Percentile	W	(lbs)	Percentile		B.P.	Health Plan N	ıme	
<u> </u>								·		
TO BE FILLED IN B	Y PROVIDER				<del></del>					
HISTORY INITIAL	/INTERVAL		٠.						T_	
Comments		·.		•					P	
NUTRITIONAL ASS		] Adequate	[ ]	Inadequate	[ ] Rei	ferred			-	
SENSORY SCREEN		Within normal li			] Yes		No, Refer		R_	
		: Within normal li Within normal li			] Yes ] Yes		No, Ref <del>er</del> No, Refer			*
DEVELOPMENTAL	ASSESSMENT	Age appropriate?	?	Ĭ.	j Yes	[ ]		-		
(If suspicious, do spe BEHAVIORAL HEAI					1 1/2-	, , ,	· · · · · · · · · · · · · · · · · · ·			
Tool used: (Pediatric					] Yes on, etc.)	[]	NO	· · · · · · · · · · · · · · · · · · ·		
	-	_								
PHYSICAL EXAM		COMMENTS	, A	SSESSMENT	& PLAN					
Are the following no			-			,				
£1.4	Yes No	11								
Skin										
HEENT										
Teeth										
*******************************										
Nodes										
Heart	·									
Lungs					•	•				
Abdomen							•			
Ext. Gen.								•		
Extremities										
Spine/Neuro		Follow-up nee	edec	1?				[] Ye	, []	No
LAB/SCREENING		IMMUNIZAT			ENT			, ,		
		Did this child	rec	eive all imm	mizations due	todaví	?	[ ] Ye	[]	No
Tuberculin Test		ls there a curr	rent	immunizatio	on record in th	e medi	cal chart?	į į Ye		
ANTICIPATORY GU	IDANCE					REF	ERRALS			
[ ] Good health hal [ ] Family and socia [ ] Good parenting [ ] Regular physical	bits and self-care al interactions practices	[ ] Dental [ ] Commo [ ] Peer rel [ ] Nutrition	unio latic	ation			Dental Behavioral CRS Specialty	Health		
Next scheduled visit		Clinician Nam	ne			Clini	ician Signatu	ie		
Was this claim coded as	an EPSDT Visit (H	CFA-1500)?		[ ] Yes	[ ] No					

# Early and Periodic Screening Diagnosis and Treatment TRACKING FORM 10 YEARS

TO BE FILLED IN	BY OFFICE ST	AFF:					
Last Name		Name	AHCCCS ID		D.O.B.		Age (Years)
Date of Examination	Ht. (in)	Percentile	Wt_(lbs)	Percentile	B.P.	Health Plan N	ame
TO BE FILLED IN B	Y PROVIDER						
HISTORY INITIAL Comments	/INTERVAL						T
NUTRITIONAL ASS	ESSMENT [	] Adequate [	l Inadeouate	e []Refe	<del>rre</del> d		P
SENSORY SCREEN	Vision:	Within normal li	mits? [	] Yes [	No, Refer		R
		Within normal li			No, Refer		
DEVELOPMENTAL	Speech:	Within normal li	mits? [		No, Refer		
(If suspicious, do spe				] 1c2 [	. 1 140		
BEHAVIORAL HEAD	LTH ASSESSMEN	VT Referral inc	licated? [		] No		
Tool used: (Pediatric	Symptom Check	klist, parental inte	rview, observati	on, etc.)			
PHYSICAL EXAM		COMMENTS	. ASSESSMENT	& PLAN			
Are the following no				,			
Skin	Yes No	,		•			
HEENT							
Teeth							
Nodes							
Heart							
Lungs							
Abdomen  Ext. Gen.					•		
Extremities							
Spine/Neuro		<b>   </b>					
LAB/SCREENING							
Tuberculin Test		Follow-up nee	ded?			[ ] Ye	s [ ]. No
Urinalysis			ION ASSESSM				
Hct./Hgb		Did this child Is there a curr	receive all imm ent immunizati	unizations due to on record in the	today? medical chart?	[ ] Ye [ ] Ye	
ANTICIPATORY GUI	IDANCE				REFERRALS		
[ ] Good health hale [ ] Social interaction [ ] Good parenting [ ] Educational actif [ ] Sexuality educate	pits and self-care ns practices vities				[ ] Dental	l Health	
Next scheduled visit	· · · · · · · · · · · · · · · · · · ·	Clinician Nam	ee		Clinician Signatu	ire ,	· · · · · · · · · · · · · · · · · · ·
Was this claim coded as	an EPSDT Visit (H	CFA-1500)?	[ ] Yes	[ ] No			

## Early and Periodic Screening Diagnosis and Treatment TRACKING FORM 12 YEARS

TO BE FILLED IN	BY OFFICE ST	CAFF:					
Last Name		Name	AHCCCS ID	<del></del>	D.O.B.	· · · · · · · · · · · · · · · · · · ·	Age (Years)
Date of Examination	Ht. (in)	Percentile	Wt.(lbs)	Percentile	B.P.	Health Plan N	ame
	<u> </u>				<u> </u>		
TO BE FILLED IN B			· <del></del>				
HISTORY INITIAL	/INTERVAL		•				1
Comments			,				P
NUTRITIONAL ASS	•		] inadequate	e [] Refe	erred		
SENSORY SCREEN		Within normal lin Within normal lin	•		[ ] No, Refer [ ] No, Refer		R
•		Within normal lin			No, Refer		
DEVELOPMENTAL			[	] Yes	[ ] No	-	
(If suspicious, do spe BEHAVIORAL HEAI				] Yes	No	,	<del></del>
Tool used: (Pediatric					. ,	·	·
PHYSICAL EXAM		COMMENTS,	ASSESSMENT	& PLAN			
Are the following no	rmal? Yes No		•				
Skin	162 140				•		
HEENT			•				
Teeth			4				
Nodes							
Heart		11					
Lungs							
Abdomen					,	ı	
Ext. Gen.							
Extremitles							•
Spine (scoliosis)		1					
Neuro			•				
2º Sexual Dev.				•			
Other		11					
LAB/SCREENING		Follow-up need	led?		•	[ ] Ye	s [ ] No
Tuberculin Test		IMMUNIZATI	·	ENT			
		Did this adoles	cent receive all	immunizations	s due today?	[ ] Ye	5 [] No
Urinalysis		Is there à curre	nt immunizati	on record in the	medical chart	Y [ ] Ye	
ANTICIPATORY GUI	IDANCE				REFERRALS		
		·			[ ] Dental		
[ ] Good health hab [ ] Social interaction			Dental Care ex education		Behavior	l Health	
[ ] Good parenting	practices	[ ]A	cademic activi	ties	[ ] Specialty	<del></del>	
[ ] Behavioral change	ges of early adole	scence			[ ] WIC		
Next scheduled visit		Clinician Name	<del></del>		Clinician Signa	tige	
						•	
Was this claim coded as	an EPSDT Visit (H	CFA-1500)?	[ ] Yes	[ ] No			

### Early and Periodic Screening Diagnosis and Treatment TRACKING FORM 14 YEARS

TO BE FILLED IN	BY OFFICE ST	AFF:	<del></del>					
Last Name		Name	AHCCCS ID			D.O.B.		Age (Years)
								1
Date of Examination	Ht. (in)	Percentile	Wt.(Ibs)	Percentile		B.P.	Health Plan	Name
	,				•			- 10214
TO BE FILLED IN B		•						
HISTORY INITIAL, Comments Mena	/INTERVAL	LMP:	_					Τ
Comments went	rene	LMIP		urrent Meds:		-		<b>D</b>
NUTRITIONAL ASSI	ESSMENT [	] Adequate	[ ] Inadequate	[ ] R	eferred			
SENSORY SCREEN		Within normal l	•	] Yes		No, Refer		R
		Within normal l		] Yes		No, Refer		
DEVELOPMENTAL A		Within normal I		] Yes		No, Refer No		
(If suspicious, do spe				1 163	£ 1 .	MO	•	
BEHAVIORAL HEAL				] Yes	[]	No	<del></del>	<del></del>
Tool used: (Pediatric			•				······································	
<u> </u>		· · · · · · · · · · · · · · · · · · ·				·····		
PHYSICAL EXAM		COMMENTS	, ASSESSMENT	& PLAN				
Are the following nor	ma1?							
THE MIC TORDWING HOL	Yes No				•			
Skin			•	•			•	
HEENT			•		1			
Teeth				·				
Nodes	·· <del>·</del>							
Heart		1						
Lings								
Abdomen		{ }						
Ext. Gen.					•			
Extremities								
Spine (scoliosis)		!				•		
Neuro								
2º Sexual Dev.								
Other								
LAB/SCREENING				•				
Tuberculin Test		1]		•			=	
Hct./Hgb.		Follow-up ne					[] }	ies [] No
Urinalysis (recommended	<del>;;   </del>	IMMUNIZA	TION ASSESSM	ENT				
	<u> </u>		escent receive all					les [] No
		Is there a cur	ent immunizati	on record in t	the med	ical chart?	[ ] 7	ies [] No
ANTICIPATORY GUI	DANCE				Dr C	ERRALS		
ANTICITATOR GUI	DANCE				K Z			
[ ] Good health hab		1 3	Dental Care			Dental Behavioral	Health	
[ ] Good parenting		<u> </u>	Nutrition		ļįį	CRS		
[ ] Counseling about		· [ ]	Educational ac Pregnancy prev			Specialty _ WIC	<del></del>	
[ ] and a micraciion		1 1	viegnancy bie	-CHUOII		Other		
Next scheduled visit	· · · · · · · · · · · · · · · · · · ·	Clinician Nar	ne		Сит	ician Signati	ire	
	••				.			
Was this claim coded as	an EPSDY Vide ra	CEA-1500)?	[ ] Yes	[ ] No	<del></del>			
	· · · · · · · · · · · · · · ·		( ) 100	f 1 14¢	•			

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NO.949 P.20

#### Early and Periodic Screening Diagnosis and Treatment TRACKING FORM 16 YEARS

TO BE FILLED IN	BY OFFICE S	TAFF:	·				<del></del>
Last Name	First	. Name	AHCCCS II	D	D.O.B.		Age (Years)
	•						
Pate of Examination	Ht. (in)	Percentile	Wt.(lbs)	Percentile	B.P.	Health Plan N	lame
O BE FILLED IN B	Y PROVIDER						
HISTORY INITIAL Comments Mena	/INTERVAL arche:	LMP:	<del></del>	Current Meds:_			Т
NUTRITIONAL ASS	ESSMENT [	] Adequate	[ ] Inadequa	ate [*] Ref	i <del>zrred</del>	,	P
SENSORY SCREEN	Vision:	Within normal l	imits?	[] Yes	[ ] No, Refer		R
		: Within normal l		[ ] Yes	[ ] No, Refer		
DEVELOPMENTAL		Within normal l		[ ] Yes [ ] Yes	[ ] No, Refer		
If suspicious, do spe					[ ] 140	-	
BEHAVIORAL HEA				[ ] Yes	[ ] No		
Tool used: (Pediatric	Symptom Chec	klist, parental int	erview, observa	ation, etc.)			<u> </u>
HYSICAL EXAM		COMMENTS	s, ASSESSMEI	NT & PLAN			
re the following no	rmal?						
•	Yes No	,					
kin				•			
EENT							
eeth							•
iodes							
leart							
ungs		111					
bdomen							
xt. Gen.							
xtremities	····· <del> </del>		•				
pine (scoliosis)							
leuro						•	
Sexual Dev.		111	•				
************************							
ther							
AB/SCREENING							
uberculin Test		Follow-up ne	eded?	•	•	ר ו א	es [] No
lct./Hgb.			TION ASSESS	MENT	'		
Trinalysis					an due today?	r ı v	es [] No
				all immunization ation record in th	ns due today? ne medical chart?		es [] No es [] No
NTICIPATORY GU	IDANCE				REFERRALS		
] Good health ha ] Good parenting ] Counseling abo ] Pregnancy prev	practices ut sexual activity	[ ] Educat y [ ] Social	Care tional activities interactions ng, alcohol, dr	•	[ ] Dental [ ] Rehaviora [ ] CRS [ ] Specialty [ ] WIC [ ] Other	l Health	
Vext scheduled visit	<del></del>	Clinician Na	me	<del></del>	Clinician Signat	ture	
Vas this claim coded as	EDCTYP COLLA	4CEA-1500\2	[ ] Vec	[ ] No			

JUN.11.2001 4:31FM

17U.747 F.CI

### Early and Periodic Screening Diagnosis and Treatment TRACKING FORM 18 YEARS

TO BE FILLED IN	BY OFFICE ST	AFF:					
Last Name		Name	AHCCCS ID		D.O.B.		Age (Years)
	•						•
Date of Examination	Ht. (in)	Wt.(lbs)	B.P.	Health Plan Name	<u>.                                    </u>		
	, ,						
TO BE FILLED IN B							
HISTORY INITIAL Comments Mena	/INTERVAL	LMP:		1-41-00-14-1			Τ
Comments Well	actic.	LMP:		irth Control:	<del></del>		
NUTRITIONAL ASS	ESSMENT [	] Adequate	[ ] Inadequate	[ ] Referre	ed		P
SENSORY SCREEN	Vision:	Within normal li	imits? [		] No, Refer		D
1		Within normal li	•		No, Refer		
DETEL OPLOSTOLI		Within normal li		] Yes [	No, Refer		
DEVELOPMENTAL (If suspicious, do spe				] Yes [	] No	_	•
BEHAVIORAL HEAD				] Yes [	No		
Tool used: (Pediatric					, 110		
·							
PHYSICAL EXAM		COMMENTS	, ASSESSMENT	& PLAN			
Are the following no		COMMENTS	, ASSESSIVICIAT	Q PLAIN			
we me tonowing no	Yes No	11	•			•	,
Skin	163 140	11 .		•			
HEENT							
Teeth		] ]					
Nodes			•				
		11					
Heart							
Lungs			ē				
Abdomen		]					
Ext. Gen.							
Extremities							
Spine (scoliosis)							
Neuro							
Peivic & Pap Smear	·						
LAB/SCREENING			•	•			
Pregnancy Test		·					
Screening for Syphilis, Chlamydia, Gonorhea					•		
Chlamydia, Gonorrhea Tuberculin Test							
		Follow-up nee	ided?			[ ] Yes	[ ] No
Hct./Hgb.		IMMUNIZAT	ION ASSESSM	ENT			
Urinalysis		Immunization	is current?			[ ] Yes	[ ] No
		<u> </u>	<u> </u>				
ANTICIPATORY GUI	DANCE			R	EFERRALS		
[ ] Dental Care		f 1 Educati	anal activities	ן נ	] Dental		,
Plans for the fut	ure		onal activities ealth habits	ļŢ	] Behavioral Healtl ] CRS	· — ·	<del></del>
[ ] Social interaction		[ ] Smokin	g, alcohol, drugs		] Specialty		
[ ] Pregnancy preve	ntion	[ ] Counse	ling about sexua	l activity	] Gynecology ] Prenatal Care	r 1	Other
Next scheduled visit		Citatalan Na	·	1			
****** STREAMEN ARE!		Clinician Nam	IC .	١٥	llinician Signature		
Wee this slate and t	- 77677		, ,				
Was this claim coded as	an EPSDT Visit (H)	LFA-1500)?	[ ] Yes	[ ] No			

### Early and Periodic Screening Diagnosis and Treatment TRACKING FORM 20 + UP TO 21 YEARS

TO BE FILLED IN	BY OFFICE ST	IAFF:	· <del></del>			
Last Name		Name	AHCCCS ID		D.O.B.	Age (Years)
Date of Examination	Ht. (in)	Wt.(lbs)	B.P.	Health Plan N	iame	
			·- <del></del>			• •
		<u> </u>		1		
TO BE FILLED IN B		•				,
HISTORY INITIAL Comments Birth		Managaba				T
Comments birth	Control:	Menarche:	L	MP:	-	
NUTRITIONAL ASS	ESSMENT [	] Adequate	] Inadequat	e []Ref	erred	• ——
SENSORY SCREEN		Within normal li	mits? [	] Yes	[ ] No, Refer	R
		: Within normal li		] Yes	[ ] No, Refer	
DEVICE OBSCENES		Within normal li		] Yes	[ ] No, Refer	
OEVELOPMENTAL (If suspicious, do spe				] Yes	[ ] No	**
BEHAVIORAL HEAL				] Yes	[ ] 'No	
Tool used: (Pediatric					( ) 140	•
					· · · · · · · · · · · · · · · · · · ·	
DHYSICAL SYARA		COMMENTS	A 5 6 5 6 5 A 5 A 5 A 5 A 5 A 5 A 5 A 5			
PHYSICAL EXAM		COMMENTS	ASSESSMENT	& PLAN		
Are the following nor		11				
Skin	Yes No					•
HEENT						
**************************						
Teeth-						
Nodes						•
Heart						
Lungs						
Abdomen						
Ext. Gen.						•
Extremities		111			•	
Spine (scoliosis)						•
Neuro	···-		•			
Pelvic & Pap Smear			•		•	
LAB/SCREENING						
Pregnancy Test						•
Screening for Syphilis, Chlamydia, Gonorrhea						
Tuberculin Test		Follow-up nee	cied?			[ ] Yes [ ] No
Hct./Hgb.		IMMUNIZAT	ION ASSESSM	ENT		
Urinalysis		Immunization				[] Yes [] No
				·	<del></del>	[ ] [ ] 140
ANTICIPATORY GUI	DANCE				REFERRALS	
					[ ] Dental	•
[ ] Dental Care [ ] Good health hab	ite and relf.com	[ ] Education [ ] Physical	onal activities		[ ] Behavioral Hea	lth
Social interaction			activity g, alcohol, drug:	<b>,</b>	[ ] CRS	
Pregnancy prever			ing about sexua		[ ] Gynecology	
				·	[ ] Prenatal Care	[ ] Other
Next scheduled visit		Clinician Nam	ıė		Clinician Signature	
Was this claim coded as	an EPSDT Visit (H	CFA-1500)?	[ ] Yes	[ ] No		